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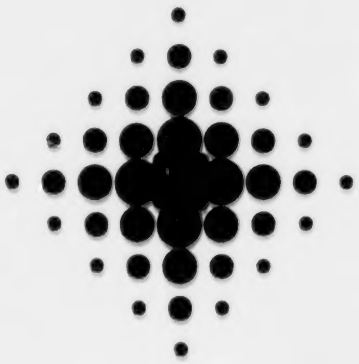
Synthèse critique

Community - Initiated Health and Social Services

Eric Shragge
Taylor Letourneau



COMMISSION D'ENQUÊTE
SUR LES SERVICES DE SANTÉ
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Community-Initiated Health and Social Services

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Position Paper Submission to
Commission d'Enquête sur les
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INTRODUCTION

This position paper will describe the emergence of a "new solidarity" and mutuality that developed in working-class neighbourhoods, among local citizens, and in particular among youths and women, in the social movements of the 1960s and 1970s. One of the important expressions of this solidarity was the development of social and health services initiated and supported by these groups. These new forms of social provision were not isolated from wider social movements, and this context brought with it support, particularly of a political nature, that could be used to push for a combination of autonomy and funding. These new "alternative agencies," as we will refer to them, also benefitted from a variety of state financial support programs; but one consequence of state funding was that they had to sacrifice their autonomy and at times shift their direction in order to be eligible for these monies.

This position paper argues that alternative social service and health agencies provide an innovative, flexible service to their respective communities. Because they tend to be relatively smaller than state agencies, and because they grew out of a particular community process or social

movement, they are accessible to and supported by the populations they serve. In many respects, these agencies played a pioneering role in the development of approaches later utilized by government agencies, for example the movement from community clinics to C.L.S.C.s. We do not think that these agencies are given enough support; they have been forced to move from one government program to another and face underfinancing and instability. Funding that guarantees both their autonomy and their stability is the position we will argue.

Our position paper is divided into four parts, followed by a conclusion. Part One sets out both some definitions of the alternative community agencies and some debates from a feminist perspective on the nature of community care and voluntarism. In this section, we situate the recent emphasis on community as a locus of the social services in the context of the cutbacks and crises of the welfare state. The second part describes the historical context in which the alternative agencies developed, a period of political turmoil and social activism leading to large-scale social reform by government, particularly in the health and social services. Part Three briefly summarizes case studies of five alternative agencies, carried out in 1985-1986, by a research group at McGill University's School of Social Work. Part Four examines the issues of funding and autonomy and the two-sided nature of state funding. We conclude with a summary and recommendations.

PART ONE

DEFINITIONS AND ISSUES

In this section we will set out some definitions of community-initiated health and social services alternative agencies and some of the issues they face in the current period. Deslauriers et al. contrast popular groups with self-help groups. Popular groups bring together individuals committed to democratic forms of organization, either formal or informal; are in touch with the concrete problems in their milieu; work toward social change in opposition, direct or indirect, to the dominant power; and attempt to maintain as much autonomy as possible from the state, despite the fact that many of them receive government grants. Priority is given to social change. In contrast, self-help groups are viewed as less oriented toward large-scale social change, and more toward the satisfaction of the particular needs of their members. Although they may take up social causes, their basic priority is their service orientation to a particular group.[1]

As well, self-help groups begin with the individual problems of their members (e.g., alcoholism, cystic fibrosis, etc.), while popular groups begin with a wider critique of the society. Thus, the orientation of the latter tends to be social, as opposed to the former, which places more emphasis on the individual. As a result, the two types of groups tend toward different kinds of actions. Popular groups oppose alienating and hierarchical services, and often end up in a conflictual relation with the state, while self-help groups provide more individualized help, usually psycho-social in nature. One can summarize this difference as one between an emphasis on political social change and an orientation to direct service.

These distinctions are helpful in contrasting "ideal" types. In practice, however, the distinctions blur, so perhaps a continuum is a more adequate way of working with these definitions, with those exclusively oriented toward self-help on one side and politically oriented popular groups on the other. The alternative agencies tend to have characteristics of each. Although they tend to be service oriented, at times they are involved in campaigns for social change, particularly as such change affects the rights and position of their members. As well, they are often part of networks of similar agencies that put pressure on the state for funding, recognition, and general support. Thus, in the process of gaining resources, these agencies engage in a

political process that leads beyond the issue of allocation, and raises questions of control and the orientation of services. The alternative agencies move along this continuum, depending on their immediate funding position and the social context. When there are increased activity and demands from social movements or community groups, these agencies will tend to be part of that wider mobilization. Alternative agencies may therefore be arranged on a continuum with greater or less political emphasis or movement toward more service-oriented work, but always within a wide political context and a potential for engagement. In other words, they are not isolated from the wider concerns in their milieu.

A similar continuum exists for the issue of who actually delivers the services. The alternative agencies have tended to be less reliant on professionals as agency workers. On the other hand, the reality is that continuity and long-term commitment require some kind of permanence in staffing. Staff may include people from within the group receiving service and volunteers. Training for these staff members is gained through experience and shared situations, while others on staff may have professional training. It is necessary for those with professional training to be conscious of the way that that training structures roles and relations, particularly with regard to those requesting service. Thus, those professionals who accept jobs in these

settings tend to be exceptional insofar as they are expected to depart from some aspects of the socialization of their education, particularly in terms of hierarchical relations with those receiving service, definition of their problems, and egalitarian relations with other staff members without formal training.

Two additional dimensions should be added here. If the alternative agencies to be discussed are different from state social agencies and services, how are they different? The first dimension is the content of their program, and the second is their organizational structure. In each instance, one can see whether or not bureaucratic, hierarchical structures and traditional forms of treatment utilized in more traditional social agencies are reproduced on a smaller scale in the alternative agencies. Programs with a more collective approach, which do not attempt to individualize wider problems, are one aspect of alternative programs. As well, these programs may include preventive work, broader public education (as opposed to treatment), and explicit links with a wider network of alternative or like-minded organizations. Thus, on the political-service continuum, alternative programs should reflect some change-oriented activity, even if it is at the level of individual consciousness and perceptions of the social origins of individual situations.

Traditional state agencies tend to be bureaucratic, with policy, orientation, and practice being determined at

the top, through either professional or technocratic criteria. Those at the receiving end of the service, those in the community around it, and line workers have little or no control over policies and programs. Democratic and participatory structures are another aspect on which to analyze the differences. Even if there is a formal democratic structure in the alternative agencies, how does it work in practice, and to what extent do pressures from the outside, through either high demand for service or demands from funding bodies, shape the degree of democracy practiced. Again, these are the questions that have to be explored in practice.

These definitions and questions will be used later in our analysis of the case studies and will contribute to our understanding of both the potential of these groups as part of a process of social change and the possible benefits of alternative social service in providing accessible social and health services that meet a variety of needs and are democratically controlled.

At present, community-based social and health services have become more important as an adjunct to state services, often because, in the current economic context, resources to expand the network of state services have been limited. This renewed interest in these services has to be viewed as problematic. There is a temptation by governments to develop social policies that emphasize provision in the community and through the family. Government social agen-

cies thus act to integrate voluntary labour and to facilitate the use of generally underfunded community-based social and health services. The alternative agencies we are discussing may receive state funding and support if they play the role of absorbing the overflow that results from state services that have been cut back or were traditionally underfunded.

The development of the welfare state redefined the balance between what was traditionally regulated and provided through the marketplace and what the state would provide, particularly through income support and health and social services, on a universal basis. Medicare, contributory and non-contributory pensions, unemployment insurance, and a variety of social services have become part of daily life in Canada and other capitalist democracies. Within a wide political spectrum, there was an acceptance of these programs and their expansion as both necessary and desirable. With the economic uncertainty that began in the mid-1970s, which was characterized both by high levels of inflation and unemployment and by a slowing of economic growth and an increase of state debt, produced in part by the growth of social programs, the welfare state itself became more of an issue. Attempts were made to curb state expenditures, and large cuts in social programs resulted. In addition, challenges to large-scale welfare emerged from the right. As George and Wilding point out:

> The era of consensus politics and near universal support for the mixed economy and the welfare state is over. . . . The welfare state was a product of a peculiar coincidence of circumstances--a post-war sense of solidarity, economic growth, Keynesian principles of economic management and confidence in government's ability to right wrongs.[2]

The period from the mid-1970s to the present has been one not only of cutting of social programs, but of reorganizing or restructuring them. This has included shifting services and programs from the state to the private sector and/or voluntary agencies, and has been referred to as privatization. One aspect of privatization has been the shifting of services from state agencies to community-based, "voluntary" agencies.

Many of the community-based alternative agencies have been supported by the provincial government through the "Organismes Bénévoles" program. However, the effects of this support are contradictory. Partial funding has given the alternative agencies increased legitimacy and provided a minimal amount of stability, particularly if the services provided act to complement the network of state social services. But these alternatives are treated as "cheap" social services relative to the funding provided to the state social services, and they are severely underfinanced in terms of the demands for service they face and of the salaries received by their workers. The rape crisis centres and refuges for battered women, for example, act to complement

the state social and health services, and yet they are funded as "second-class" cousins in the social service delivery system.

This current period of redefinition and the opening up of debate on the health and social services provide an opportunity to lend legitimacy and support to community and popularly initiated agencies, which could with adequate financing provide flexible community-based services with participatory structures. However, there remain issues that must be confronted arising out of feminist and trade-union critiques of community services and voluntarism.

Both Elizabeth Wilson[3] and Janet Finch[4] have presented interesting analyses of community-based social and health services. Wilson begins by contrasting traditional assumptions about women's roles, "equated with various 'good' characteristics of family life and community life," with those of men "out in the world of commerce and industry." This division parallels the separation of life into two spheres: the private--women and the household--and the public--men, workplace, and politics. The private sphere is primarily responsible for the reproduction of labour power and the related work of social caring. Regarding the relation of the state to provision, she argues, ". . . the whole trend of post-war welfare care has been dominated by the idea that whenever possible care should occur in the 'community' rather than in mammoth institutions." However, "... in practice, financial constraints have meant that there

have never been enough of these forms of extra-familial care."[5] Essentially, community care has relied on the private sphere and on women as its primary givers, and therefore the current cutbacks imply more community responsibility, which means adding an increased burden onto women in their caring role.

Janet Finch asks if caring is necessarily women's work and if the community is necessarily women's space. The current community orientations assume the availability of volunteers--who tend to be women. Further, new categories of low-waged work linked to community care jobs have tended to be filled by women, and women tend to be the primary domestic caregivers in the home. "Community," as it has been defined by those engaged in social policy, tends to be confined to women and their activities. Thus, ". . . community [is] fundamentally a gendered concept, at least as it is utilized in these contexts. Without social and cultural transformation of a very fundamental sort 'the community' will remain women's space, just as 'caring' will remain women's work."[6]

Similar arguments have been made by feminists in relation to the use of volunteers in community-based agencies. Baldock argues that: ". . . voluntary agencies are only able to satisfy the changing and ever-increasing demands for their services because of the availability of unpaid <u>female</u> volunteers who combine volunteer labour with

other unpaid work, namely that carried out in domestic settings."[7] Although men do perform voluntary roles, these are often an extension of their paid work and power, while voluntary work for women is a replacement of paid work. Women tend to be more available because of their position of economic dependence and the dominant ideology in our society that women are supposed to be caregivers. Baldock links this situation to the sexual division of labour in families.[9] This is a powerful critique and leads to the argument adopted by some women's groups that volunteers should not be used, particularly in direct service, as this continues the dependency and traditional role of women.

Trade unions have concerns along the same lines about the impact of the use of volunteers on jobs. The use of free labour for service provision can be understood as a means through which the state can undercut wage levels and jobs for public-sector workers. As well, workers in the community alternative agencies tend to receive low wages and are not unionized, thus providing a cheap alternative to higher-paid state workers.

With the current restructuring of social and health services, and with greater emphasis on the use of volunteers in providing support services, there is certainly a basis for concern by the women's movement that their free labour will be used to act as a buffer against cutbacks in the public sector, and by trade unions that volunteers will be

mobilized to undermine public-sector jobs and weaken their bargaining positions.

The community-based alternative agencies we have studied have been caught in a dilemma. They are underfinanced, and have faced periods of instability in their funding. Yet, for the most part, they have evolved in such a way as to use paid staff for the major part of their service delivery and to avoid using volunteers as labour for most of their direct services. Volunteer roles have been defined, at the level of the board, as support to alternatives, as a means of linking the service alternative to the community, and at times in special programs. The agencies we have examined have not fallen into the problems raised by the women's movement. However, relative to government services, these agencies are inexpensive alternatives, unless agency staff are paid at the same levels as those in the public sector. This is the situation in two of our cases--AMBCAL and Pointe St. Charles Community Clinic. If alternative agencies are to play a more effective role in the service delivery system, the staff should be paid adequately, and financial stability should be accorded to them, which would improve their complementarity to state agencies and other points of service for particular problems and needs. These changes would avoid the problems of community services becoming linked to domestic labour and to voluntarism as women's free labour, and would help to solve the problem of

providing relatively inexpensive services in a period of economic restraint. If money is to be saved it could be through reducing the large administrative costs linked to state services not associated with community alternatives.

NOTES

[1] Jean-Pierre Deslauriers, Jean-François Denault, Pierre Chavannes, and Michel Houde, Les Générations de Groupes Populaires de Sherbrooke (1970-1984) (Sherbrooke: Université de Sherbrooke, Collection Recherche Action no. 6, 1985), pp. 20-24.

[2] Vic George and Paul Wilding, The Impact of Social Policy (London: Routledge and Kegan Paul, 1984), p. 247.

[3] Elizabeth Wilson, "Women, the Community, and the Family," in Allan Walker (ed.), The Family, the State, and Social Policy (Oxford: Basil Blackwell and Martin Robertson, 1982).

[4] Janet Finch, "Community Care: Developing Non-Sexist Alternatives," Critical Social Policy (Spring 1984).

[5] Wilson, op. cit., pp. 45-47.

[6] Finch, op. cit., p. 12.

[7] Cora V. Baldock, "Volunteer Work as Work: Some Theoretical Considerations," in C.V. Baldock and B. Cass (eds.), Women, Social Welfare and the State in Australia (Sydney: George Allen and Unwin, 1984), p. 280.

[8] Ibid., p. 290.

[9] Ibid., p. 292.

PART TWO

HISTORICAL CONTEXT

In this section we will describe the context (1960s to the present) in which the alternative agencies developed. These projects did not emerge in isolation, but were part of a period of social mobilization and political agitation, and developed within the context of shifts in the roles assumed by the state in the economic and social spheres.

Situated historically, the alternative agencies we will discuss grew out of and alongside a wider context of community and trade union activism and were part of a search for social alternatives and for improved social conditions. In Quebec during the 1960s, the emergence of the anti-poverty and working-class movements, student activism, the counter-culture, and, later, the women's movement were accompanied by heightened Quebec nationalism and growing labour unrest. Throughout the late 1960s and early 1970s, popular struggles were organized on a variety of socio-economic, cultural, and environmental fronts. The broad spectrum of social problems and unmet local needs which these social movements increasingly brought out in the open resulted in the development of

a wide range of community-based agencies aimed at improving local living and working conditions.

In their origins, the agencies we will discuss were connected to these wider social and cultural movements. Two of the clinics, Clinique Saint-Jacques and the Pointe St. Charles clinic, developed in working-class Montreal, responded to inadequate services in those neighbourhoods, and were part of a wider awakening of working-class consciousness and demands for radical social change. Another clinic, Head and Hands, grew out of the counter-culture of the 1960s, and was a means to address the unmet social and medical needs of local youths. The youth-serving agency, AMBCAL, emerged out of the English-speaking anti-poverty movement, and initially responded to the needs of low-income citizens. Finally, CAPAS, the rape crisis and prevention centre, was originally linked to the women's movement and grew out of the mutual aid and solidarity of women against violence.

These agencies were not isolated examples of community initiative, but emerged during a period of contest and urban struggle when dozens of citizens' groups sprang up to challenge the authorities on issues which ranged from housing and social services to education and local transport.

Several authors have traced the history and context of the development of Montreal popular groups and citizen organizations.[1] Four periods can be roughly described.

Period 1: The Citizens' Committees

Between 1960 and 1968, a number of experiments in citizen participation were initiated in the older, low-income areas surrounding Montreal city centre, in particular in the communities of Saint-Henri, Pointe St. Charles, Centre-Sud, and Hochelaga. The citizens' committees which emerged out of these experiments were, in many cases, linked to the efforts of professional social workers attached to traditional service agencies and to federal and provincial youth employment programs which sponsored the development of a new "animation sociale." Inspired by trends in community organizing in the U.S., and based on a faith in government responsiveness to organized local demand, efforts were made to organize local pressure groups. The principal aim of many of these citizens' committees was to represent local citizens and parish interests, and to pressure governments to have local housing, health, and education problems recognized and addressed:

> De 1963 à 1968, toute la pratique des groupes de base est orientée vers des revendications immédiates et locales. Leur action se caractérise par un certain réformisme, dans la mesure où ils recherchent des changements dans les structures et tentent de faire bouger les autorités par des moyens légaux. On constate une absence de stratégie globale, une analyse des problèmes de la pauvreté trop superficielle. La société est acceptée telle qu'elle est, c'est l'individu qui doit changer.[2]

For the most part, therefore, the citizens' committees which emerged in these working-class neighbourhoods during the early 1960s began to articulate local social and health

needs and were based on liberal notions of citizen participation and social integration.

In other, less economically depressed areas, community-based citizens' committees were not a new phenomenon. In these neighbourhoods, however, new citizens' committees, often related to the youth movement and later to the women's movement, were started and a new range of social needs was identified. The first street clinics, for instance, which appeared in 1967,[3] grew out of the initiatives of citizens' committees, composed of local residents, streetworkers, and youths. The development of these "counter-clinics" was a response both to the paucity of local services and to their inability to meet the specific medical and social needs of the youth population.

Period 2: Shifting Orientation

During the late 1960s, there was a major shift in the orientation of many of the citizens' committees and a movement away from lobbying efforts directed at the state to new forms of social critique and collective organization. Having discovered that the government was not responding adequately to local needs and demands for service improvements, many citizens' committees were transformed into mutual aid associations, social advocacy groups, and service organizations. Alongside the development of local, collective community solutions, which included the creation of day-care

centres, popular education centres, food cooperatives, and community clinics, was the establishment of anti-poverty, welfare rights, and tenants' groups.

For a number of other committees, which had closer links to growing social activism and union militancy, broader social change objectives were adopted. In a number of working-class neighbourhoods, local "comités d'action politique" (CAPs) were organized, representing a clear break from the kind of naiveté and humanism which had previously oriented many local citizens' groups. The subsequent development of a political action movement at the municipal level, with the formation of the Front d'action politique (FRAP), resulted from a desire not only to contest the 1970 municipal elections, but also to create a place of convergence for popular struggles in Montreal.

The climate of social unrest and political challenge at this time was further intensified by the deteriorating relations between the Quebec government and the public-sector unions, and by the opening by the C.S.N. of its "second front" of political and social action. As well, it was during the period near the end of the 1960s that the "mouvement souveraineté-association" became firmly established.

Period 3: The Growth and Diversification of Community Groups

The early 1970s were characterized by the continued development and diversification of popular groups, which, as

they became more numerous, addressed different social needs, and by the beginning of a new struggle, which continues today, by many popular groups to maintain autonomy in the face of the major health and social service reforms contained in the Quebec government's Bill 65. Following the "October Crisis" and FRAP's electoral defeat and subsequent dissolution, some groups connected to this struggle disbanded, and while other groups returned to more single-issue-oriented struggles, a third group of popular agencies began to draw on and engage in increasingly radical analyses of the social and economic conditions that confronted them on a daily basis, and to explore the connections between class, poverty, exploitation, and ill health. One of the responses taken by the state to the political turmoil of the period was legislation which envisaged the transfer of power and control of local initiatives from the community to the state. For many groups, Bill 65 represented a threat, both to local citizen participation and to freedom of programming.

In a 1974 study of Montreal citizens' groups in several working-class sections of the city, nearly 140 popular organizations and groups, serving a total low-income client population of approximately fifteen thousand, were documented.[4] Several "general" organization types were proposed to describe these groups, which varied from "meals on wheels" and welfare rights groups to community legal clinics: 1) groups formed to defend communities against major urban re-

newal projects; 2) groups aimed at local community control over area decision making; 3) social advocacy groups; and 4) non-state service organizations. While the majority of the groups were identified as service oriented, these categories were not mutually exclusive, as many tenants' associations and medical clinics, for instance, combined service delivery with social and political action.

Meanwhile, on a different front, the women's movement in Quebec began to evolve as a new social force during the 1970s, and as women's health and social needs were identified, a new range of local women's organizations was created.[5] The expansion of feminist analysis and the establishment of the first consciousness-raising groups in the early 1970s were followed by the development of women's information and referral centres. As the social taboos which had previously concealed much of the violence directed against women were removed and the extent of sexual abuse was exposed, so too was the inadequacy of traditional service forms to meet the needs of women exposed to sexual violence.[5]

The response by Quebec women's groups to these service gaps was the establishment of alternative agencies which were controlled and administered by women and which offered service relations distinct from the public service network, which, during the mid-1970s, did not even recognize the needs of women exposed to sexual violence. The first bat-

tered women's shelter was established in 1975, followed by the creation of the first rape crisis and prevention centre in 1976.[6]

Period 4: Uncertain Future

The period from the mid-1970s to the present has been characterized both by a reorientation, and in some sectors an expansion, of many of the alternative agencies, and by struggles to survive financially and to maintain local autonomy with regard to the state.

A period of "crisis" within community groups, characterized by ideological reflection and by a decline in community mobilization led to a reorientation to more services among many popular groups. In other sectors the late 1970s and early 1980s have been a period of expansion, especially among women's organizations.

While the need for community-based alternative resources obviously continues to exist, the current economic context and period of state redefinition, which includes public-sector cuts, funding freezes, and increasingly tight bureaucratic controls, have placed increased burdens on the alternative agencies and have forced many groups to question and reconsider the relations between these agencies and state funding programs.

Conclusion: The Changing Quebec State

Paralleling the growth and development of the alternative agencies, the Quebec state underwent economic changes, particularly after 1960. The state under Duplessis, particularly in the economic and social welfare sphere had been "anti-collectivist," encouraging a free market and giving over social welfare and health programs to private charities and the church to administer. The "Quiet Revolution," launched with the Lesage government of 1960, shifted this orientation, and the Quebec state came to be understood as the vehicle for large-scale social and economic change, and as the promoter of the development of the Quebec society.

We will not pursue a discussion about the development of the Quebec state here, as other position papers will do this, but we raise it as part of a wider context and vision, particularly during the early part of the period. Although there were always tensions and basic conflicts between the popular movement and the state, there was also a fundamental assumption that the government's support of health and social service would grow and would be forthcoming, or would at least allow a variety of social experiments. These ideas were linked to a period, particularly until 1975, of strong economic growth, high levels of employment, and working-class strength. These economic conditions facilitated expansion in the health and social services, and created confidence in the "milieu populaire" that change was possible.

The ensuing world-wide economic crisis had its effect in Quebec. Not only did unemployment climb rapidly, but the government attempted to weaken the demands of the unions, particularly in the public sector. Social spending stagnated and many programs were cut. The current administration is pushing ahead with the privatization of many services and a redefinition of the role of the state in the economic and social spheres. It is in this context that the alternative agencies we will describe seek funding and support. The orientation of the state to the financing of programs has changed since the beginnings of these alternative agencies. The issue they face is what role they will play in the redefined orientation of the Quebec state.

NOTES

[1] The discussion of the evolution of Montreal popular groups and citizen organizations is derived from the work of: Donald McGraw, Le développement des groupes populaires à Montréal (1963-1973) (Montréal: Les Éditions Coopératives Albert Saint-Martin, 1978); Marc Raboy, "Urban Struggles and Municipal Politics: The Montreal Citizens' Movement," International Review of Community Development 29-40 (Summer 1978); Claude Larivière, "L'intervention en milieu urbain: du professionalisme au militantisme," International Review of Community Development 39-40 (Summer 1978); Marielle Désy, Marc Ferland, Benoît Lévesque, and Yves Vaillancourt, La conjoncture au Québec au début des années 80: les enjeux pour le mouvement ouvrier et populaire (Rimouski: La Librairie socialiste de l'Est du Québec, 1980), chapter 5; Pierre Hamel, Jean-François Léonard, and Robert Mayer, eds., Les Mobilisations populaires urbaines (Montreal: Nouvelle Optique, 1982), Introduction to first section; and Jacques Godbout, La participation contre la démocratie (Montreal: Les Éditions Coopératives Albert Saint-Martin, 1983), chapter 3.

[2] Jacques Godbout and Jean-Pierre Collin, Les Organismes populaires en milieu urbain: contre pouvoir ou nouvelle pratique professionnelle? (Montreal: INRS-Urbanisation, Rapports de recherche, 3, 1977), p. 60.

[3] See Erica Bell and Nancy Guberman, "Community Health Clinics: A Study of Innovative Service Delivery to Alienated Urban Groups," M.S.W. Research Report (McGill University, 1971).

[4] Godbout, op. cit., pp. 71-78.

[5] See Micheline Beaudry, Les Maisons des femmes battues au Québec (Montreal: Les Éditions Coopératives Albert Saint-Martin, 1984); Fiona Colgan, "Quebec Shelters for Abused Women: Has Anything Changed?," perception (May/August 1986); and Louise Bessette, "Regroupement provincial des maisons d'hébergement: une ressource alternative?," perception (November/December 1985).

PART THREE

CASE STUDIES

The summaries presented in this chapter are derived from five recently completed case studies of Montreal non-state health and social service agencies. Each summary will provide an overview of the different origins and operational philosophies and activities engaged in by the agencies studied, and will conclude with a description of the different funding arrangements each group has developed.

AMBCAL (West Island Youth Project)

At present, the AMBCAL West Island Youth Project provides emergency youth care and community youth programs to young people and their families in the West Island area of Montreal. AMBCAL has retained its community organization status and is funded through a contractual agreement with the provincially mandated Youth Horizons service agency.

Origins

AMBCAL was established as the A-Ma-Baie Community Action League in Pierrefonds, in the West Island area of Montreal, in 1971. A-Ma-Baie is a low-income area within a relatively affluent community, and when AMBCAL emerged it focused on the socio-economic needs of its community and became part of the Greater Montreal Anti-Poverty Coordinating Committee. Early services developed by the agency included cooperative daycare, consumer advocacy, food and clothing depots, and youth work.

Organization and Activities

When the C.L.S.C. in Pierrefonds opened in 1975, most of the Community Action League responsibilities were transferred to the state sector. AMBCAL became the West Island Youth Project, and its focus shifted from social action to youth services. AMBCAL maintained community status--autonomy, community-based board of directors, and paraprofessional approach--and directed itself toward meeting the various needs of youths on the West Island.

AMBCAL's focus became crisis intervention, and a community-based support system was utilized which aimed at integrating the resources of the community with the more specialized social service delivery system. Later, advocacy and diversion objectives were adopted, and AMBCAL's services included an emergency shelter, foster care, streetwork, groupwork, counselling, and referrals.

AMBCAL presently provides emergency care services using a traditional child-care model, within which it has integrated an alternative methodology. Thus, in addition to an individually focused treatment plan, AMBCAL has identified the wider context of family, school, peers, and community as integral factors in the change process.

AMBCAL has moved away from its early paraprofessional approach and, at present, is staffed by professionally qualified child-care workers. Staff members work closely as a team and, in cooperation with AMBCAL's director and community board of directors, share in decision making regarding policy and programs.

Funding Status

During its early years as a citizen action group, AMBCAL relied on federal funding programs, including the Local Initiatives Program and Health and Welfare grants. Financial survival proved difficult, however, and in the mid-1970s AMBCAL supported the development of a C.L.S.C. in order to obtain community-based services which would operate with a secure funding base. In 1976, AMBCAL sought, and was refused, a "purchase of service" agreement with the new C.L.S.C. Persuasive lobbying by the community, however, convinced the Ville Marie Social Services Centre (V.M.S.S.C.) to fund the youth project, though this arrangement was neither permanent nor secure. Finally, after sev-

eral options were considered, including integration into the state network, a contractual agreement was established with Youth Horizons, a state-mandated youth service, for the joint operation of an emergency shelter.

At present, therefore, the Ministry of Social Affairs, through Youth Horizons, provides the agency with financial support. AMBCAL has preserved its community status and has retained a certain flexibility in service development and a closeness to the community that state organizations lack. AMBCAL is small, and its board of directors and use of volunteers both help make it more responsive to community needs. Its staff are not unionized, which means that while they benefit from union contracts negotiated between child-care professionals and Youth Horizons, a certain local flexibility in the management of staff time and worker rules has been maintained. Also, because as a community organization AMBCAL is free to apply for other sources of program support, it has been able to develop a more diverse set of services and activities.

AMBCAL has established a unique relationship, as a community organization, with Youth Horizons. AMBCAL's autonomy is partial, however, as the general standards and practices of the public network must be conformed to, including certain hiring requirements and a process of client referrals. Resource problems and backlogs within the public network are pushing AMBCAL away from its emergency status toward a more long-term group-home orientation. Also, pres-

sures to fully integrate continue, and only in 1984, due to strong board pressure, was AMBCAL able to successfully resist integration into a large residential treatment facility.

Centre d'Aide et de Prévention d'Assauts Sexuels de Châteauguay

The Centre d'Aide et Prévention d'Assauts Sexuels (CAPAS) currently provides women in the town of Châteauguay, on the outskirts of Montreal, with rape crisis and prevention services. CAPAS is an autonomous women's organization, operating on annual grants from the Ministry of Social Affairs' support program for community agencies.

Origins

CAPAS first emerged in 1979 and was the result of local initiatives taken by women, who were increasingly aware of both the widespread nature of sexual violence and the lack of support and services available to women. Existing state agencies, including the C.L.S.C. in Châteauguay, had no protocol for dealing with the short- and long-term needs of women exposed to sexual abuse or to violence. When CAPAS first opened, its rape crisis line was staffed by volunteers and the centre offered advice, referrals, and emo-

tional support to women with regard to rape, violence in the home, incest, and sexual harassment.

Organization and Activities

The philosophy and practice of CAPAS have evolved since its establishment in 1979: it has shifted from its original goal of providing self-help services for rape victims, to include an ever-increasing commitment to social change. Having moved from its early concern with "treating the victim," CAPAS is determined to treat rape and violence against women as a political issue, which has led to both a feminist approach to service provision and a stress on preventive education and political action. Although direct aid remains a priority, CAPAS devotes considerable time to consciousness-raising activities and cooperation with other women's groups. This evolution in theory and practice also included the decision to move away from a hierarchical structure in order to function as a collective. This approach, which includes consensus decision making and a stress on a woman-to-woman rather than a professional-client approach, is seen as appropriate for a group which wants to work to change the power relations between men and women, but which, in doing so, does not wish to create new ones between women.

Funding Status

Initially, CAPAS operated on volunteer labour and attempted to be self-financing. The municipality paid for the rape crisis phone line, and the C.L.S.C. made office space available. Eventually, however, CAPAS opted for state financial support as a means to ensure its ability to deliver quality services and to provide the possibility for expansion. The concern was that as little energy as possible should be devoted to the time-consuming and often ineffective treadmill of fundraising. Since 1980, the centre no longer devotes its energy to bazaars and bake sales, nor to various government grants, which are seen as piecemeal and for which there are often no follow-up grants. In 1981, CAPAS received a Federal Works Programme grant, and since 1982 it has received annual funding through the Ministry of Social Affairs' support program for community agencies. However, grants from M.A.S. are intended to provide partial funding and are not guaranteed, and the amount awarded annually is not known in advance; this makes long-term planning difficult.

In 1979, CAPAS joined a provincial coalition of rape crisis and prevention centres, le Regroupement Québécois des Centres d'Aide et de Lutte Contre les Agressions à Caractère Sexuel (CALACS), as a means to protect itself from potential cooptation and from the strings often attached to state funding. CALACS has formed a common front against govern-

ment pressure on centres for services to be provided in an institutional form, which would include an increasing professionalization of workers and the keeping of files and statistics on women seeking help. CAPAS has described its participation in CALACS as a necessary and important tactic for the preservation of its identity, which includes a combination of direct aid with a commitment to social change.

CAPAS and the eight other centres involved in CALACS have also joined together to fight for more adequate and secure funding for rape crisis and prevention centres. It is CALACS' view that women, as taxpayers and citizens of Quebec, have the right to receive and have access to state-funded services which are suited to their specific needs.

In terms of state support, the C.L.S.C. in Châteauguay has been instrumental in helping local community groups, including CAPAS, through the provision of office space, photocopying, community worker time, and so on. Quebec government policy, however, which has suggested cooperation between state and alternative agencies, is vague. In the face of this confusion regarding government intentions and CAPAS' own preference for complete autonomy, CAPAS is on its guard concerning its position with and its relation to the C.L.S.C.

La Clinique Communautaire de Pointe St. Charles

The Pointe St. Charles Community Clinic has existed for eighteen years, and has provided residents of the Pointe St. Charles community, an economically deprived area south of downtown Montreal, with a combination of health and social services. The Pointe St. Charles clinic has become part of the provincial network of C.L.S.C.s and, as such, is funded primarily through the Ministry of Social Affairs. The clinic is not a C.L.S.C., however, and remains classified as a non-profit community organization.

Origins

The Pointe St. Charles clinic was founded by medical students from McGill University in the spring of 1968. Because of a growing interest in the health problems of inner-city families and the urban poor, the Pointe St. Charles community, which exhibited both a lack of local medical facilities and generally poor health levels, was selected by the medical students as an appropriate site.

Organization and Activities

When the clinic first opened, it intended, in addition to the training of medical students and an assessment of the soundness of the concept of satellite clinics, to provide the community with a new model of health service

nity service which combined comprehensive direct medical service with preventive programs, and to begin an analysis of local health problems within the broader socio-economic context of Pointe St. Charles. The involvement of community members in the definition of local needs and in clinic administration increased during the first few years, and as part of the new model of health care a family-health-worker program was initiated, where local citizens were trained to assist the medical personnel in the delivery of care and in the teaching of preventive medicine.

Throughout its history, the Pointe St. Charles clinic has committed itself to a philosophy which situates the delivery of health and social services within the social and economic realities of the community. It was during the 1970s, however, that the link between "ill health and capitalism" was most forcefully stated. At this time, the clinic shifted its priorities from the training of medical students and the provision of direct medical services to include a more radical and political conception of health care. Accompanying an emerging class analysis was a growing critique of traditional medical practices, which emphasized the treatment of symptoms and ignored the social and environmental causes of sickness. Political education and community organizing became primary clinic objectives.

Not everyone involved in the clinic held the same ideas about practice and political activity, however, and

from the middle to the end of the 1970s, the clinic fell prey to extreme factional infighting, which, in many cases, disrupted service delivery and alienated a large segment of the community. In the 1980s the clinic has moved away from critical political analysis, and has increasingly returned to its original community health model, which combines direct services with a preventive orientation. Specific programs currently offered by the Pointe St. Charles clinic include: medications at reduced cost, maternal and child health, youth health, health at work, inform-action for the elderly, health action, relaxation/"détente," dental project, eyesight project, and community development projects. Services and follow-up are provided by three multi-disciplinary teams, each working in a designated geographical area.

Local citizen involvement in clinic decision making remains a priority and is defined, for the most part, by its citizen board of directors, which is elected by a general assembly of area residents. However, as the Pointe St. Charles clinic has become increasingly large, complex, and specialized, with over seventy full-time workers, the power and influence of professional clinic workers in shaping clinic direction has grown; this, combined with the growing role played by government, has, at least to some degree, threatened local control. Although clinic employees have been unionized since 1974, a principle of non-confrontation

between the workers and the citizen board of directors has been written into the collective agreement.

Funding Status

Initially, the Pointe St. Charles Community Clinic was privately funded, through donations and foundation grants. In the early 1970s, the clinic sought government support, first with federal Health and Welfare grants, and subsequently from the Quebec government. Since 1972, the principal source of clinic revenue has been the Ministry of Social Affairs, in the form of annual global budget allocations, contractual agreements with the Regional Council (C.R.S.S.S.), and receipts from the billing of medicare (R.A.M.Q.) for clinical medical services, from which doctors' salaries are derived. During the 1970s the clinic operated with a temporary license as a C.L.S.C., and in 1983 it was granted a permanent C.L.S.C. license. This funding arrangement is unique, however, because, although it is licensed as a C.L.S.C., the Pointe St. Charles clinic remains classified as a non-profit community organization, and has maintained administrative and service characteristics which define it as such.

Since 1972, when a joint general assembly of local community groups, fearing the loss of local citizen power and the clinic's freedom of programming, massively rejected clinic integration into the C.L.S.C. network, the Pointe

St. Charles clinic has secured both provincial funding and some measure of independence. Thus, although the clinic receives its global salary budget as determined by M.S.S.Q. salary scales, this amount is then redistributed according to the clinic's own salary policies, which aim to reduce income disparities among workers. Clinic autonomy and citizen control, however, are partial; although the clinic has successfully defended its community board of directors and its own personnel and wage policies, funding relations with M.A.S. have shaped clinic evolution. It is increasingly difficult to harmonize the ideas of citizen control and collective intervention with the growing complexity, technocratic philosophy, and service requirements attached to service mandates imposed by the provincial government.

La clinique des citoyens de Saint-Jacques

Between 1968 and 1986, the Saint-Jacques Citizens' Clinic provided residents of the centre-south and Plateau Mont-Royal areas of Montreal with a combination of direct health services, popular and preventive education, and an opportunity for local involvement in the administration and delivery of health services. In 1986, the clinic's staff and services were integrated into the newly developed C.L.S.C. Plateau Mont-Royal.

Origins

The Saint-Jacques clinic emerged in 1968 and was the result of collective action taken by a local citizens' action group to address the health needs of the highly disadvantaged community of Saint-Jacques, in the centre-south area of Montreal. Initial efforts were directed toward lobbying governments for improvements to the local health-care infrastructure; however, when these efforts failed, the Saint-Jacques Citizens' Committee shifted its energies toward a new vision of autonomous, collective citizen control. The Saint-Jacques clinic was established as an alternative model of health-care delivery, which would be administered by and responsive to the needs of the largely working-class population. Until 1970, the Saint-Jacques clinic operated on the basis of volunteer workers, and medical services were offered free of charge.

Organization and Activities

From the outset, the operational philosophy of the Saint-Jacques clinic reflected a commitment both to the provision of needed and financially accessible community health care and to an understanding of and attempt to change broader socio-economic conditions linked to poor health. Like the Pointe St. Charles clinic, the Saint-Jacques clinic also became increasingly involved during the 1970s in a number of popular struggles aimed at improving local living and work-

ing conditions. Within the clinic itself, efforts were made to avoid traditional hierarchies and power relations through citizen participation in clinic administration, teamwork in service delivery, the use of paraprofessionals, and client education aimed at demystifying medical knowledge. Opportunities for local citizen involvement in clinic decision making were established through the clinic's general assembly, its board of cooperative members, and a wide variety of working committees.

During the 1980s, broad community participation and clinic socio-political mobilization had both substantially diminished. The Saint-Jacques clinic, however, continued to offer local residents, in addition to general medicine and psychiatric services, medications and dental and psychological services at reduced cost.

Funding Status

In 1970, following several years of financial difficulty connected to its early reliance on small grants and donations, the Saint-Jacques clinic adopted a cooperative funding formula. Throughout the 1970s and early 1980s, small family membership dues--$2.00 per family in 1970 and $4.50 in 1983--accounted for approximately one-third of the clinic's annual operating budget. Other sources of clinic income during this period included Centraide grants, and revenue, above the salaries paid to medical personnel,

from the Régie de l'assurance-maladie du Québec (R.A.M.Q.). Centraide discontinued funding the clinic in 1978, arguing duplication of state services. However, the clinic viewed this cut as a political act directly linked to the clinic's involvement in social advocacy and political action.

In 1979, after twelve years of struggle for financial survival, a growing deficit forced the clinic to consider new funding options. Finally, a decision was taken that state financial support should be allocated to the clinic for its role in the provision of essential and accessible health services. Starting in 1980, the Ministry of Social Affairs, through its support program for community and voluntary organizations ("organismes bénévoles") began to provide the clinic with a yearly subsidy which eventually accounted for one-third of the clinic's operating income.

Nevertheless, in the early 1980s, serious questions were once again raised about the continued operation of the Saint-Jacques clinic. The historical lack of sufficient and stable resources, downward fluctuations in community involvement, and uncertainty surrounding C.L.S.C. development and the continuation of M.A.S. financial support all began to take their toll on the clinic. As these internal and external pressures intensified, the lure of better wage conditions and more secure operating funds attached to a C.L.S.C. gained renewed significance. During this period in the clinic's evolution, members found it increasingly diffi-

cult to believe that the clinic could emerge from a struggle for complete autonomy with all its parts--services, modes of practice, accessibility, and professional staff--intact. In the fall of 1982, the general assembly voted in favour of a negotiated integration of the Saint-Jacques clinic into the new C.L.S.C. Plateau Mont-Royal. The decision to integrate was therefore taken at a time when the clinic's future was uncertain: poised between the threat of clinic closure or privatization and transformation into a public service organization. Attempts made by the clinic to secure a funding arrangement similar to the one established by the Pointe St. Charles clinic were rejected by M.A.S. Survival for the Saint-Jacques clinic has meant integration into the C.L.S.C., the loss of programs such as medication at reduced cost, and the adoption of a hierarchical administrative structure.

Head and Hands

Head and Hands is a youth clinic located in the Notre-Dame-de-Grâce (N.D.G.) community, west of downtown Montreal. For the last sixteen years, Head and Hands has offered young people across the island of Montreal a range of health, counselling, and community services. Head and Hands has developed as an autonomous, community-based organ-

ization and operates on a diverse funding base, which includes annual grants from the Ministry of Social Affairs.

Origins

The idea of opening a street clinic in N.D.G. grew out of the West End Youth Action Committee (WEYAC), a local citizens' group composed of streetworkers, youths, and concerned parents formed in 1969 to address the issue of unmet social and medical needs among neighbourhood youths. Youths were going unserved, WEYAC argued, not only because gaps existed in the established health and social service system, but because many youths simply distrusted and therefore avoided these traditional resources. During the late 1960s, few services existed where youths could comfortably go for drug counselling or for concerns related to sexuality. When Head and Hands emerged, in the fall of 1970, it offered general medical and gynaecological services, counselling, and handicrafts.

Organization and Activities

The service philosophy of Head and Hnads has changed very little over the years, and the clinic continues to devote itself to the provision of community youth services which are both responsive to local needs and accessible to the youth population. Accessibility has meant avoiding the faults inherent in more traditional settings; Head and Hands

has intentionally created an informal environment, operates on a drop-in basis, and is open in the evenings. The original medical and counselling services have since been supported and complemented by the development of additional programs including streetwork, legal services, health education, job banks, pre-school programs, tutorial services, and community festivals.

Head and Hands is often referred to as a collective; it operates with a philosophy of teamwork, consensus decision making, and equal remuneration among staff members. Most major decisions are made through weekly staff meetings. The clinic's community board of directors plays a complementary role, providing support and work on such global issues as funding and clinic survival strategies.

Head and Hands' status as an alternative youth-serving community resource is further defined by its small size (in 1984 there were nine full-time staff members), the emphasis it has placed on community outreach (including links to the local community council), and its combination of curative with preventive services. Volunteers played a significant role in the creation of Head and Hands, and they continue to figure prominently at all levels of agency operations, including the clinic's board of directors.

Funding Status

During its initial years, Head and Hands relied on a combination of volunteers, small donations, and streetwork-

ers paid by the Y.M.C.A. Later, clinic youth workers were supported by Opportunities for Youth (O.F.Y.) grants, which were subsequently replaced by Local Initiatives Program (L.I.P.) grants, followed by a three-year Health and Welfare Non-Medical Use of Drugs (N.M.U.D.) grant. In the mid-1970s, sponsorship shifted from the federal government to the Quebec Ministry of Social Affairs' Organismes Bénévoles program. Since 1979, M.A.S. subsidies, which in 1984 constituted forty percent of the clinic's budget, have been supplemented by the receipt of annual grants from Centraide. Financial support from these two sources has been, and remains, only partial. By necessity, therefore, Head and Hands has constantly sought additional sources of income, including grants from other funding agencies, service contracts, medical office rentals, membership campaigns, and fund-raising events.

State support has not eliminated Head and Hands' funding problems, nor has it safeguarded the clinic's future. While closure due to a lack of funds has been a never-ending threat, the short-term and insufficient nature of government funding programs has also constrained long-term planning, resulted in low worker wages, and channeled clinic energy into the search for funding supplements. Moreover, since 1981, when M.A.S. announced the intention to complete its network of C.L.S.C.s, the future of Head and Hands has been unclear. With the establishment of a C.L.S.C. in N.D.G., will state continue to support alterna-

tive community services such as Head and Hands? The government has not spelled out the role it envisages for well-established community and voluntary projects.

Head and Hands, having considered a variety of options ranging from service contracts to C.L.S.C. integration, remains committed to preserving its autonomy as a youth-serving community organization, with a full range of services and its own style of operation. The clinic wants to continue the complementary relationships with state and community service structures for which it has worked during the past sixteen years. The need continues, it is argued, for community resources which offer youths an alternative to services offered by the public network.

Head and Hands has requested both formal recognition and a secure funding base. In addition, the clinic has recently joined a coalition of youth-serving organizations, le Regroupement des organismes communautaires pour la jeunesse (R.O.C.J.), and has engaged in several campaigns designed to increase government awareness of the social and fiscal value of non-state community-sector organizations.

That Head and Hands has survived its "grassroots" origins and continues to operate can be attributed to several factors, including the clinic's proven capacity to mobilize community, political, and material support, its historical and now well-established role in local service giving, and, finally, its accent on prevention, which has clearly matched stated Quebec health and social service policy.

PART FOUR

AUTONOMY AND FINANCING ALTERNATIVE AGENCIES

As the case studies show, community alternative agencies emerged within the context of social movements and a wider popular culture. They found both support for and local sensitivity to their projects. Yet, in order to provide the service that was needed, they had to find more funding than their respective milieus could generate. Often, this meant turning to government or to private foundations or charities. Very quickly, these agencies lost at least some autonomy as they entered into the complex and slippery game of funding. Their very autonomy or self-definition was put on the line, and a dynamic of conformity to funders' demands and priorities and conflict in defending programs ensued. At times, the nature of the alternative agency itself became the stake in a game defined by a complex series of trade-offs between programmatic and organizational changes in relation to demands of funders. As long as there is no viable self-financing option, this relationship will be central in the definition of alternative, community-based health and social services.

The range of options open to these agencies is at the same time varied and limited. In the case studies we point out how each agency has worked out a different relationship with its respective funding group. Yet each agency has faced both some uncertainty and changes in its own objectives in order to fit into funders' categories. The range of grants includes short-term employment grants and parts of federal or provincial government job-creation programs, which are short-lived, not well adapted to the service orientation of these agencies, and often inject a disproportionately large number of staff for specific projects over a short period of time. Some agencies turned to branches of the Ministry of Social Affairs in Quebec, and before that to Health and Welfare Canada, for support. Altered priorities of both of these ministries have forced agencies to define their programs in relation to what was "in" in any particular period. Yet these priorities did not have staying power, and these shifts forced changes in programming and orientations. Some agencies have turned to private charities, such as Centraide in Montreal, and have been able to get funds on a fairly consistent basis from them. However, this is limited in particular by attempts by Centraide to restrict the more "political" aspects of activity, through forcing groups to have government-registered "charitable" or "educational" status for purposes of taxation,[1] thus eliminating activities with overt oppositional activities. Ser-

vice contracts between alternative and government agencies is another option.

In terms of the options presented, government recognition and funding with autonomy to pursue activities independently is ideal. However, because the government does not easily relinquish control, this option has not been open to many alternative agencies. Their experiences show that there are many trade-offs between the service delivery that is expected and the limits this puts on other programs and structures. Finally, some alternative agencies have become part of the network of government services, completely giving up their independence. Each of the alternative agencies we have presented has had to face difficult options, and the tension between having funds to provide adequate, innovative services while maintaining group autonomy is always there. Although desirable, self-financing has not been a viable option for any of these groups.

How can we explain the different outcomes for these groups and what factors may lead to groups achieving better funding possibilities? Hamel proposes several explanations for why the state funds groups. These should be considered in relation to the balance of strength between popular groups and the government, and to the large amounts of money given to groups since the 1970s.

1) In the context of cutbacks to the welfare state programs, the role and contribution of voluntary organi-

zations become more important, and these can be used as a means to reduce costs of state social services.

2) As a means of establishing and elaborating a social consensus, political representatives can link up with these popular groups.

3) Groups have succeeded within the context of the crisis of the welfare state because of their combativeness.[2]

These hypotheses are neither comprehensive nor mutually exclusive, but they do indicate some of the ambiguities involved. Further, the state does have a stake in controlling these groups, whether it is because of the oppositional content of their activities or so that the cutbacks in state welfare can be more easily managed through using the alternative agencies as a less expensive option.

When examining the experiences of the agencies studied, we can see these forces in play. If groups want to protect autonomy and receive government funding, then they have to have a wider base of support than their own agency. Some groups have been able to develop and sustain fairly good support from individuals and from other community groups, and have an independent board which has been able to help in mobilizing support. Other groups may also be part of a wider coalition that is trying to negotiate with government, and that respond to and offer policy alternatives. If a group is part of a federation of groups with similar

interests, its strength, derived from both local support and wider alliances, is enhanced.

The balance of forces discussed above can be situated in a wider context. Alternative health and social services do not develop in a vacuum, but in the context of wider social and political movements. There is nothing new about this. Early working-class history presents examples of mutual-aid societies, predating the welfare state, that provided death and sickness benefits. As social movements develop, they not only present demands for social change, but also build mutual aid as one aspect of their activity. Thus, two of the clinics we analyzed in the case studies grew out of a milieu of wider social struggle: a new urban social movement, comprising organizations of the poor, a more militant working class and trade unions, and a nationalist sentiment. The other cases have their origin in the youth, women's and anti-poverty movements.

In each instance, popular support for these alternative agencies, particularly in their early phases, was one reason they received state funding: the government's response to these movements, for better or worse, was to fund that aspect of them. Separating the service component from the more political aspects is one way of giving in yet not capitulating to other demands for change. Social movements are loose, and tend to rise and to fade. When they are on the downswing, groups providing service lack wider support,

and they tend to end up as isolated service providers. Autonomy with local and wider support is thus a key factor in the development of democratic local agencies that can meet needs in innovative ways and provide services that are easily and directly accessible. At the same time, however, this requires funding with very few strings attached. Funding bodies, as we have pointed out, tend not to trust local groups with the power of self-definition, and therefore funds tend to be attached to specific programs and to funders' definitions. If groups become weak or isolated, these forces have even greater impact and services can be easily distorted and depoliticized.

Susan Schechter,[3] in her study of the battered women's movement in the U.S., and in particular the shelters and programs they developed, argues that services and politics should not be separated from each other. As opposed to more traditional social agencies servicing battered women, alternative agencies convey "to battered women and to the society why women are beaten and what social conditions must be changed to end violence," and they argue that violence is linked to "women's general social subordination." With an exclusively service orientation, "women will be unable to turn their individual fault into a social problem . . . [and] will see themselves as different, weaker than other women."[4] Thus, battering becomes disconnected from the larger struggles of the women's movement. Yet at the same

time, caring and services are required. This balance is essential. An integration of democratic structures and an ongoing analysis of violence are both components of the balance between service and political change. The issue, then, is: Given that groups pursue outside financing, how do grants distort this goal and view?

There are many ways for the more innovative and radical content and structures of community alternative agencies to become transformed. Schechter presents the following: funding guidelines tend to push programs in the direction of individualized services--professional counselling and advocacy for individuals. As one worker in a shelter points out, "It's easy to slide into a 'client-provider' attitude. What the money does is institutionalize the relationship. It divides people's time differently. It changes how you view people."[5] Grants often stipulate the transformation of organizational structure in order to be eligible. This includes a clear division of labour and responsibility, requiring a shift from a collective to a more hierarchical form of organization.[6] Thus, shared responsibility by all staff and volunteers is diminished, while divisions between administrators, service providers, and clients become accentuated, and the more collective aspects of the service are reduced.

Once an alternative agency is funded, staff are put in a position of having to raise more money in order to

guarantee and to maintain an adequate level of services. As a consequence of this dynamic, the attack on social causation of the issue the alternative agency initially addressed is pushed to the "back burner." Further, funded groups have to give priority to administration and to their image in relation to both funders and the potential "client" population. Thus, controversial issues are less likely to be confronted. Further, as agencies receive funds, they are then expected to serve larger populations, and they face a wider spectrum of problems and needs.[7] Funding begins to have the consequence of defusing the more political and change-oriented aspects of the program. As Schechter points out, "the government's view that a social movement is irrelevant gains legitimacy as tasks are defined and conflict disappears," and "In the process of toning down the social critique, resistance to bureaucratic incursions into feminist guidelines or practices is often simultaneously lessened."[8]

Hamel's analysis follows along similar lines. He adds that the granting process and the related bureaucratic demands are demanding of time and are difficult to complete. These aspects are further complicated by the normal delays and inefficiencies of large government agencies. Further, priorities and criteria of government agencies are never stable, forcing groups to continually redefine their projects in order to receive funding. As well, grants are not indexed to inflation; and on top of the inadequate

amounts received, reductions and total cutoffs are always possible.[9] Thus, groups are left vulnerable and inherently unstable. Yet the issues are more complex. Groups' demands for funding and their gains in these areas produce their own confrontations and struggles. A balance of power develops in any given period, and gains are linked not only to the strength and organization of the group involved, but, as we pointed out earlier, to the broader support it can mobilize. A dynamic balance is struck between the power of the state to control funds and to use these funds to define both content and organizational structures, and the groups themselves; so the latter make demands for adequate revenues and attempt to protect their own autonomy and democratic structures.

Thus, in order to guard both autonomy and funding, alternative agencies are forced to live in an atmosphere of tension and instability. Is this the only possibility for these groups? Even with these restrictions, some groups have achieved a degree of success in negotiating funding while maintaining independence, which may be as a result of political sophistication on their part and/or strong community support. The demand for autonomy and funding is crucial, and groups, acting in federations, are currently in the process of working through this position. The outcome is never certain, and the logic of funding with autonomy flies in the face of the technocratic rationality and cen-

tralized planning of the Quebec government. Given the cost of implementing large-scale province-wide programs during a period of spending retrenchment, the government may be open to utilizing community-based options, but, as pointed out in Section One, there are many pitfalls that groups should be aware of. These are limited openings, but other questions, such as universal accessiblity and public accountability, have to be discussed. How can groups demand local autonomy, yet also demand universal services of good quality without large-scale state control?

These are old questions, and they indirectly challenge the underpinnings and assumptions of the modern welfare state. Traditionally, social programs and benefits were accessible to the rich if they were able to obtain services through the market, while the poor were subject to some kind of means or needs test. Universality was to bring services to all without discrimination based on economic status. Further, the only institution that was able to guarantee and plan benefits and services was the state, at either the federal or the provincial level, depending on the program. This arrangement was viewed as social progress; yet, as a consequence, it removed control of these services from the local community, creating the relationship of powerlessness and domination. Thus, the model of social progress implicitly cut out democratic forms and autonomy from the social and health services. Technocratic rational-

ity, particularly in the Quebec context, implies not only universal distribution of service but uniformity and, ultimately, centralized power.

Funding of community alternative agencies with local control implies local power to determine social and health service needs, and contradicts the tendency toward highly centralized state planning of these programs. There can be other approaches that can be taken to safeguard universal access to services on a decentralized basis. One is to give recognition to popular initiatives and to support their development as a vital part of the social and health service network. Where they do not exist, local community groups and residents can be encouraged to develop services--given high levels of unemployment this would be attractive--in conjunction with a support of "regroupements" of service groups and the regional council of the Minister of Health and Social Services.

The alternative agencies we studied have shown a remarkable ability, within the wider context of uncertainty, to fulfill basic community needs with a minimum of "professional" distancing, hierarchy, and bureaucracy. In order for the population of Quebec to benefit from some of these skills and approaches, a funding approach needs to put forward that adequately recognizes the crucial role played by these agencies which at the same time allows them scope and autonomy to respond to the diverse needs they face. Some suggestions will follow in the last section.

NOTES

[1] See Pierre Hamel, "Crise de la redistribution étatique et financement des organisations populaires," Revue internationale d'action communautaire 10 (automne 1983): 63-76.

[2] Ibid., pp. 65-66.

[3] Susan Schechter, Women and Male Violence--The Visions and Struggles of the Battered Women's Movement (Boston: South End Press, 1982).

[4] Ibid., p. 251.

[5] Ibid., cited p. 245.

[6] Ibid., pp. 245-246.

[7] Ibid., p. 247.

[8] Ibid., pp. 247-248.

[9] Hamel, op. cit., pp. 71-72.

SUMMARY

IMPLICATIONS AND RECOMMENDATIONS

Implications

The community-based alernative agencies we have studied were initiated by local residents, often with support of community organizers and other resource people from outside the local community. The services were established in response to particular needs that were not being met at all, or to existing services that were inadequately provided, by government or private social agencies. The founders of each particular agency acted to mobilize many community members and groups to participate in their project. As well, they received support from and were involved in the social movement and popular organizations of their milieus. Although these agencies are primarily concerned with the provision of a particular health or social service, they have worked for wider social change either with other groups, in movements, or as part of a process linked to their own funding and recognition by government and/or private agencies. Thus, the community agencies we studied are both part of an alternative network of health and social services, and linked to

the demands for social change arising from their milieus--either a geographic community or a constituency.

Paid staff have implemented and provided the services offered by these agencies. Often, these workers are paid well below the levels of corresponding workers in government agencies. Volunteers are used in diverse roles; their function as board members has been crucial, as they have been able to mobilize support and link the agency to the wider community. The tendency of these agencies is to provide direct services, but they are involved in a wide variety of service innovations and other programs, including community mobilization on specific issues, education aimed at prevention, self-help initiatives, the development of new services, community festivals, and other events. In some ways, these agencies have acted not only as points of service, but also as centres of community activity. Because of their local roots and ties with daily life, they have been able to respond in a flexible way to changes in needs and to new social problems and issues that arise. Thus, the combination of accessibility and closeness to the community has allowed an innovative service orientation to develop that is open to input from and redefinition by, on an ongoing basis, community residents, clients, and staff.

The alternative agencies have established a tradition of being less hierarchical in their structures than state agencies, and of involving both staff and community repre-

sentatives in decision making at various levels. As the case studies show, there are various organizational structures involved, including those with community boards, public general assemblies, and staff collectives. Each form has evolved through daily practice and allows staff and community participation in decision making. One key issue is size. With the exception of the Pointe St. Charles Community Clinic, the agencies tend to be small, and therefore able to operate more easily on a less hierarchical basis. Although the agencies have hired professionally trained workers, they have tried to minimize the divisions between staff with and without formal training, and between clients and workers. In contrast to government agencies, these community-based alternatives have a commitment to active participation of either community or staff or both in all aspects of agency work that goes beyond tokenism. This participation has allowed each alternative agency to mobilize support in the community at particular points in its development.

Funding has been the central concern for groups involved in these alternative services. Although, from their beginnings, they have received funding from different levels of government and from various programs, this funding has been inadequate and unpredictable. Each of the groups we have studied here developed a survival strategy that has allowed at least some autonomy. Those groups that have been able to maintain broad-based community support (or, in the

case of CAPAS, support from the women's movement) have been better able to maintain themselves. One of the problems that Clinique Saint-Jacques faced, which resulted in its integration into a C.L.S.C., was the decrease in community support. In our view, those groups that are most linked to other local groups or to social movements and that have strong citizen participation have done better and have been able to negotiate with funding sources more effectively.

The following relationships with government and other funding sources have been developed. The Pointe St. Charles clinic has a strong community board and has been able to negotiate a unique relationship with M.A.S. It is treated like a C.L.S.C., but with much more autonomy and local accountability. We see this as an excellent model, as it has provided more autonomy and some longer-term financial stability, as well as adequate salary levels for staff.

Head and Hands has a strong board, and is involved in a wide range of community activities, including the community council. These relations have allowed the clinic to mobilize support at specific points in its history. It has been able to survive economically through mixing its funding sources and using its own fund-raising campaigns. However, among the consequences of the present funding strategies are that staff tend to be underpaid, and financial arrangements persist in being insecure. Present negotiation with M.A.S. might result in longer-term funding as part of a relationship with a local C.L.S.C.

Clinique Saint-Jacques is presently being integrated into the government network of C.L.S.C.s. It was unable to negotiate an arrangement with M.A.S. similar to that of the Pointe St. Charles clinic. It had experimented with a cooperative funding arrangement in which each family unit contributed a monthly amount. In addition, outside money was received, most recently from M.A.S.'s Organismes Bénévoles program. Its integration with a C.L.S.C. reflects both demographic changes in the community through gentrification of housing and availability of private clinics, and perhaps some degree of staff frustration with chasing after grants that provide inadequate salaries.

CAPAS, in Châteauguay, receives support from M.A.S., and indirectly from the local C.L.S.C. It is involved with a "regroupement" of anti-rape centres which has attempted to negotiate a longer-term, more comprehensive agreement with the provincial government. It is understaffed, and workers are underpaid. Funding tends to be precarious, and wide educational efforts suffer as a result. Its ability to continue in the longer term is linked to receiving community support and to maintaining its relationship with the regroupement, and therefore it might have the clout to negotiate better funding arrangements.

AMBCAL has been able to survive through negotiating a service contract with Youth Horizons, a government youth-serving agency. This has allowed autonomy, a local communi-

ty board, and some stability, at least in the short term. One of the reasons it was able to negotiate this arrangement was that it narrowed its functions when the local C.L.S.C. was developed and found a service it could provide to a wider community than the geographic area it originally served.

Each of these alternative has worked out some arrangement for survival over the years. One of the key variables is the local and wide support that each agency can mobilize on its own behalf. Regroupements of these alternatives agencies are helpful in the process of negotiating with the government. However, with the exception of the Pointe St. Charles clinic, all groups face uncertainty and underfinancing. The arrangements that have been established are at best short term, and do not allow these agencies the ability to plan and guarantee longer-term services to their respective communities.

Despite the fact that many of these non-state agencies have pioneered new areas of and new approaches to service delivery and have supplemented gaps in the public service system, their establishment and development has never been a government funding priority (less than one percent of M.S.S.Q.'s total budget is allocated to private voluntary/ community organizations). Recent submissions, both to the Rochon Commission and to the M.S.S.Q., again confirm a situation that is already well known: government financial support for most community-sector organizations is tenuous at best.[1]

The position adopted by individual groups and by the large coalitions, nevertheless, whether it be community youth organizations, social advocacy, or women's centres, is that community-sector initiatives constitute an essential part of the health and social service system. Government acknowledgments of community-sector credibility and its contribution to welfare provision in themselves are no longer sufficient and must be combined with formal recognition, coherent funding policies and greater community access to government decision making.

Official, legal recognition, it is argued, which respects and ensures organizational independence, would confirm the necessity of and parallel role played by community agencies and alternative organizations. If the community sector is to properly fulfill its role and develop its resources, however, government funding must be adequate and secure. A greater allocation of funds, both to individual groups and to the wider regional coordinating bodies, perhaps on a three-year basis, would reduce the tensions attached to the present funding process and would encourage more effective long-term planning and service delivery. Included among such recommendations are the creation of specific funding envelopes and the pooling of interministerial funds. So, for instance, a new funding program for women's shelters could be established which recognizes the specific needs of the shelters and from which financing would be

based on criteria agreed to by the regroupements, other centres, and M.S.S.Q.

The elaboration and implementation of comprehensive government policies on specific social needs and the development of more consistent state funding policies necessitate a more balanced decision-making process. Community groups and regional coalitions must be consulted on and involved in all levels of policy formulation, both through the creation of new decision-making bodies composed of representatives from the community groups and M.S.S.Q., and by increasing the number of community organization seats on government committees, commissions, and establishments which are concerned with the populations served by community-sector activity.

Final Recommendations

1. The contribution of community-based alternative health and social service agencies should be recognized officially by the government. According these agencies both adequate funding and autonomy to develop their programs would be a major step toward providing flexible, innovative services designed to meet local needs.

2. Governments are usually concerned about universal access to services, planning, and evaluation. Community-initiated alternatives have not developed across the

province of Quebec. Several steps can be taken to guarantee services: a) fund existing groups as suggested in the first recommendation ; b) encourage local initiatives by supplying start-up grants and funding experienced resource people through "regroupements" of the various community alternatives. Planning and service evaluation can occur through negotiation between regroupements of the alternatives and the regional councils. Thus, the regroupements joining together the various alternative services, either on a regional basis and/or on the basis of the type of service, can play a central role in the development of these services through ongoing discussion with the regional councils.

3. Services such as the Pointe St. Charles Community Clinic--a clinic providing major service delivery in the community, yet with a strong local board, more local autonomy, and so on--and AMBCAL--service contract with institutions--seem to be viable existing models.

4. Regroupements of community-based alternatives should be encouraged and funded. Their role, besides representing the specific interests of their member agencies, could be to provide research, information, and re-

sources for those establishing new services, and their own member groups.

5. Finally, in the context of cutbacks and prvatization of services, there is a tendency among those who develop social policy to view community-based agencies, along with volunteers, as a low-cost means of providing health and social services. We have argued against this approach. Community-based alternatives may be less costly because they involve less of a bureaucratic structure, but staff should not be viewed as cheap labour, and volunteers--who are usually women--should not be expected to bear the burden of reduction in budgets to social programs.

NOTE

[1] This discussion is derived from the following reports and articles:

1) Le développement des organismes communautaires jeunesse: une nécessité, document de réflexion du Regroupement des organismes communautaires jeunesse du Montréal Métropolitain (R.O.C.J.M.M.), remis à la Commission Rochon, mars 1986.

2) La place des ressources alternatives et communautaires en santé mentale de la région 6A, par la Table régionale des ressources alternatives et communautaires en santé mentale du Montréal Métropolitain (T.R.R.A.C.S.M.M.M.), remis à la Commission Rochon, mars 1986.

3) Brief presented to the Rochon Commission, submitted by West Island Citizen Advocacy, January, 1986.

4) "Agressions sexuelles: Les centres d'aide ne sont pas à vendre," La Presse, Montréal, mardi, 25 mars 1986.

5) Renée Rowan, "Les femmes pauvres," Le Devoir, lundi, 1er décembre 1986.

6) Fiona Colgan, "Quebec shelters for abused women: Has anything changed?" perception (May/August 1986).